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AUTHOR Harris, Michael J.
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ABSTRACT

The first of the two discussions presented here, "Sleep Problems, Overtiredness and Overanxiety," describes sleeping behavior of children from birth to 3 years of age and considers situations that affect children's sleep. Topics briefly addressed include the physiology of sleep; developmental aspects of sleep patterns; the effect of lack of sleep; causes of sleep disturbance; mothering difficulties and sleep disturbances; sleep problems from birth to 6 weeks of age; the ritualism surrounding learning to go to sleep; sleep problems between 1 and 4 months of age, between 4 months and 1 year, and between 1 and 3 years; and parental overanxiety and sleep problems. The second discussion, "Frustrating Children: From Birth to Preschool," describes "problem" infants--for example, the excessive crier, the poor sleeper, the difficult feeder, and the "out-of-joint" baby (the baby who does not fit into the family system). Also discussed are frustrations associated with looking after toddlers and frustrations induced by the preschool child. Discussion of toddlers focuses on poor sleep patterns and parental overanxiety, food refusal, misbehavior, and training problems. Discussion of preschool children deals with tantrums and other misbehavior problems, stubbornness, "selective deafness," refusal to be hurried, toilet training problems, and clinging behavior. (RH)

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Selected Papers

Unit for Child Studies

Number 24

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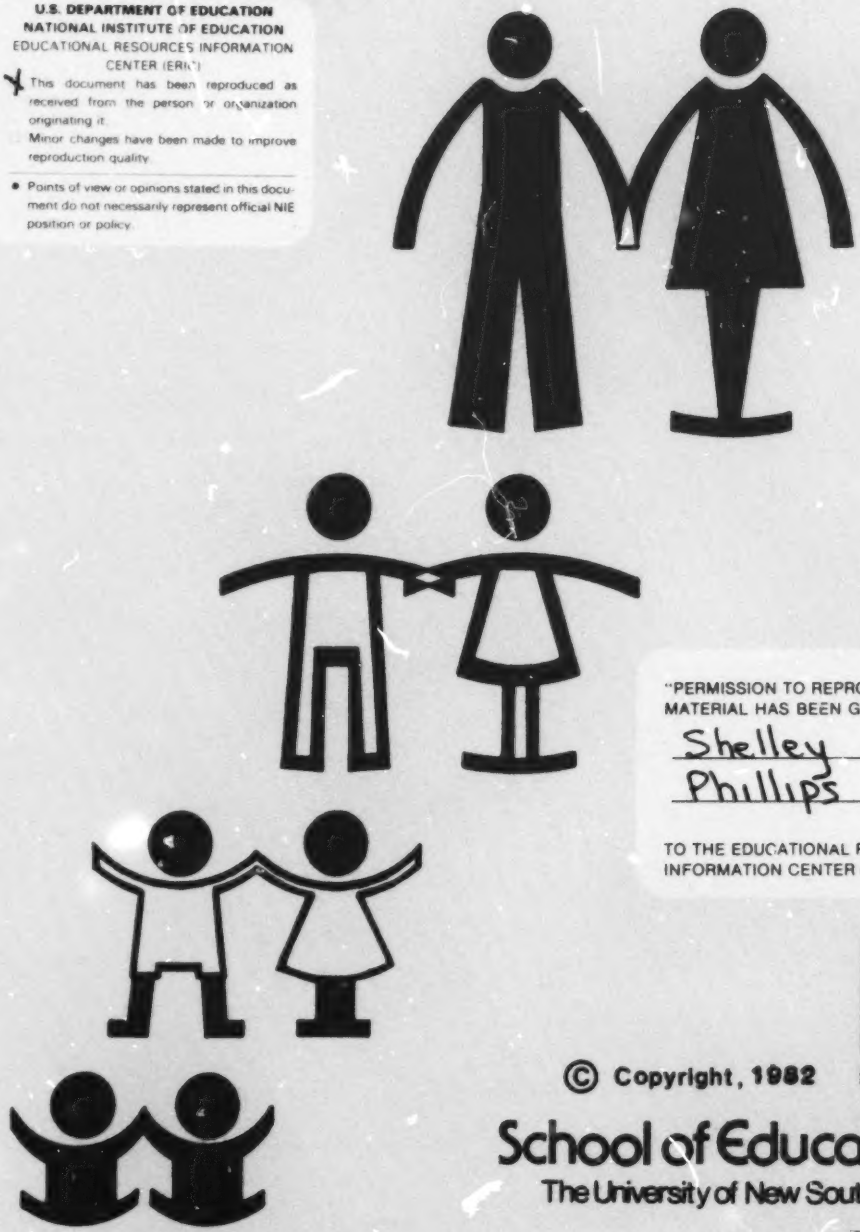

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SLEEP PROBLEMS, OVERTIREDNESS AND OVERANXIETY

and

FRUSTRATING CHILDREN: From Birth to Preschool

Dr Michael J Harris

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SLEEP PROBLEMS, OVERTIREDNESS AND OVERANXIETY

Michael J Harris
Visiting Paediatrician

Prince of Wales Children's Hospital, Randwick
Royal Hospital for Women
Paddington

Based on a seminar given on 31st May, 1982
Unit for Child Studies, School of Education
University of New South Wales.

PHYSIOLOGY OF SLEEP

There are two types of sleep - active and passive. "Active" sleep, also called "regular-eye-movement" (REM) sleep or "irregular" sleep, is associated with body movements, bladder emptying, muscle jerking, penile erections, and dreaming. "Passive", "quiet", "regular", "non-regular-eye-movement" sleep is deep and restful, without movement or dreams.

The two types of sleep occur together in cycles which last about 50 minutes at birth, 75 minutes by 4 years of age, and 90 minutes in adults. The active sleep component can be about two-thirds of the cycle at birth, but becomes about one-third or less in adults.

Babies go to sleep through an active phase but this only lasts a few months. The mechanism of this changeover is unclear. In caring for newborn babies, lights for 24 hours a day, even for months, do not seem to affect the development of normal sleep patterns.

Tiredness increases the depth of the passive phase. It does not increase the duration of the sleep cycle. It does not significantly alter active sleep.

DEVELOPMENTAL ASPECTS OF SLEEP PATTERNS

Hunger and feeding patterns are closely related to sleep patterns in the newborn period and soon after. Many babies wake screaming with hunger. However, by 4 months at least, hunger rarely dictates the pattern of day sleep. Once the infant has dropped his night feedings, it is unlikely that he wakes at night because of hunger. Even underfed children develop a 10 to 12 hour night sleep pattern in the first year of life.

The newborn sleeps about 17 to 20 hours a day. The sleep periods rarely exceed 5 hours and the wakeful periods last not more than 2 to 3 hours. By 3 months of age, seventy percent of infants sleep about 8 hours or more at night. The appearance of an elongated night sleep occurs without any relationship to breast or bottle feeding, to demand or strict feeding schedules, to birth weight, current weight or rate of weight gain, and it is not related to the potential intelligence of the baby. The long sleep may occur by the sudden dropping of a night feed or by the gradual increase in the interval between feeds. In some it may occur initially in the late afternoon or evening.

During the day, contented newborns will go to sleep immediately after feeding. By 6 - 8 weeks some will want a short "play" period after some feeds before sleep. This is a wake period, not related to an active sleep phase. It requires that the care-provider recognises the baby's desire for sleep. By 3 to 4 months the afternoon sleep period is usually considerably shortened. In most infants past 3 months of age, the number of day sleeps is related to the number of feeds per day. However, some babies "catnap" taking not more than one sleep cycle at a time or even less on a number of occasions per day.

The change from two day-sleeps to only one depends on the individual child. The total cessation of day-sleep can occur anywhere between 18 months and 5 or 6 years of age. The cessation of a day sleep may be climate-related in that the "siesta" fits into the daily pattern of all age groups in many tropical regions of the world.

Between 6 and 9 months of age, many infants who have previously slept 10 to 12 hours at night begin to wake at night. It may follow a febrile illness which disturbed the established sleep pattern and a comforting mother was then part of the required treatment. Once the pattern has developed, the child is likely to wake during each active sleep phase, make noises, and possibly call for attention. The new sleep pattern can then last for many weeks, or sometimes for months. However, as many as 10% of infants by one year of age have not slept through the night.

The sleep requirements of a child is an individual thing. The measurement of sufficiency of sleep depends on the presence or absence of overtiredness. Diminished sleep requirements may relate to higher intelligence but also to brain damage. Sleep is improved by sucking and motion and by continuous music or pulsating sound.

WHO DETERMINES SLEEP MATTERS

It is possible to indicate to infants or children when they are expected to go to sleep but it is impossible to make them sleep unless they want to. They can be put to bed, but the child has control over whether or not he/she goes to sleep. The atmosphere in the bedroom can be conducive to sleep, but the child determines whether or not to shut his/her eyes.

THE EFFECT OF LACK OF SLEEP

The myth in the community suggests that if overtired, one sleeps better that night. In fact, one sleeps deeper but for a shorter duration and the deficit is picked up the next night - if possible! Children usually never sleep better by being kept awake when tired during the day.

Tiredness and fatigue in infants and children can build up to a situation of continual day-in-and-day-out overtiredness. All mothers, sometime or other, have experienced the overtired baby or infant who cannot be cuddled, who screams, who won't be soothed, and who won't feed. Accumulated tiredness may be an important factor in producing the 6 pm colic in babies.

Chronic overtiredness may partly account for the "overactivity" of many infants and children, even from 6 months of age onwards. The 9 month old who sleeps only one hour a day may be too overtired to stop his perpetual movement, which often becomes pointless and uncontrollable. Overtiredness may

account for the difficult behaviour of the one to three year old for one to two days after spending a few days with Grandma. This is generally diagnosed as "having been spoilt".

Occasional disturbed nights are part of being a parent. Frequent night waking can be coped with by some parents, but produces tiredness in many. If it persists, or if settling the infant down takes a long time, the parents are apt to become cranky and irritable, snappy, slowed up, and disinterested. Such states are not conducive to good mothering, good parenting, or satisfactory marital relationships.

Severe sleep disturbances in the infants have been known to lead to total disruption of the family.

THE CAUSES OF SLEEP DISTURBANCE

These may arise from the baby, the parents or child-carers and/or from the environment. The child can be the originator if he/she is overtired, overanxious, unwell or brain-damaged. The parents or child-carer may ignore the signs of tiredness or may themselves be the source of overanxiety. Environmental factors include such things as the room being too hot or, perhaps, too cold, the bed being uncomfortable, the bassinet being too restrictive, the clothing being too tight or too hot, or an annoying sibling in the day time.

MOTHERING DIFFICULTIES AND SLEEP DISTURBANCES

In the first months of life, a baby will not sleep unless s/he is fed adequately, and then allowed to relax and pass happily into sleep. That requires warmth, love, and relaxation from the mother. If she is flustered, overanxious, uncertain, unwell, or in any way upset, she may transfer those feelings to the baby, who may not settle easily. Poor quality mothering engenders an anxiety in the baby which makes relaxation and sleep difficult. This can set up a vicious cycle between the baby's crying and the mother's refusal to acknowledge the baby's need.

The overanxious or the overprotective mother who constantly goes into the child's room "to see if he/she is alright" is, in fact, disturbing his/her sleep. Almost invariably he/she is aware of mother's presence, and if he/she is in a phase of active sleep, may wake and be unable to move into the next sleep phase.

SLEEP PROBLEMS FROM BIRTH TO SIX WEEKS OF AGE

During the first four to six weeks, babies ideally go straight to sleep after all feeds, and feeds usually occur every three to four hours. A few babies will be sleeping eight hours at night.

Problems include firstly, early waking which may be induced by hunger or merely express an individual irregularity of the feeding pattern and secondly, failure to settle after feeds which may be due to hunger, to inadequate quality of mothering or to insufficient sucking time.

The management of these problems includes such things as ensuring that the baby is not hungry and that he/she has sufficient sucking time with or without a dummy. Mother and baby need to relax after feeds so that sleep is possible. If the baby is particularly difficult, the child-carer must learn the techniques of establishing a sleep ritual.

In practice, it is not unusual for first-born babies to sleep much better at four months of age than at four weeks.

THE RITUALISM AROUND LEARNING TO GO TO SLEEP

Ritualism is the process by which infants and children are taught, or learn, that when certain events occur, other events follow automatically. Thus, four-month-olds know what moves and noises lead up to a pram ride with Mum. Early they know when a bath is due by the sequence of events which have been repeated almost daily for them. Some babies need more ritualistic behaviour than others. It is an individual variation, but some degree of ritualism occurs in everyone.

For the poor sleeper in the first months of life, it may be important to establish a firm ritual about going to sleep. It may involve a particular song from mother, being put down in a particular position in the same bassinet or cot, with music or a particular tape or record playing quietly and then to be rocked or patted or stroked in a particular way until sleep ensues and continues.

It can take weeks for the ritual to become effective. Once learnt, the baby or infant should be a reasonably good sleeper whose mother can get him/her down with ease anywhere and any time, provided that he/she is tired. Mothers who cannot cope with the demand on their time and patience made by establishing this ritual, will have infants who sleep badly, and develop the long-term problems of chronic overtiredness.

SLEEP PROBLEMS BETWEEN ONE AND FOUR MONTHS OF AGE

Between one and three or four months of age, some babies play before going down for the daytime sleep. Sleep problems are often related to other problems in management.

Problems include the overtired baby who fights being put down to sleep and wakes frequently. The signs of tiredness (the yawn, the whimper, or the drooping eyelids) may have been ignored. Also, the overstimulated, the anxious or the unrelaxed baby sleep poorly. The baby who is inadequately mothered may refuse to separate to be put to sleep. Dummy dependent babies at this age cannot put their dummy's into their mouths themselves. They will refuse to sleep without it and they may wake everytime it falls out of the mouth. Babies who catnap, taking an hour or less at random times during the day, may not be felt as a problem by their carers. However, it is not an ideal arrangement if the baby is not allowed to go from one sleep cycle to the next because of outside interference. Babies probably dream at this age. It is recognised by the crying during sleep. Nightmares are rarely seen.

The basic treatment of these problems requires knowledge of the cause. It is wrong to presume that babies can manage without adequate sleep. Many mothers take the easy way out, don't offer sleep as the baby seems to manage without it, and finish up with the problems of overtiredness and overstimulation at later ages.

SLEEP PROBLEMS BETWEEN FOUR MONTHS OF AGE AND THE FIRST BIRTHDAY

At some stage during the second half of the baby's first year, most babies sleep through the night. However, night waking, without crying but with talking and singing is frequent in this age group. It is not a problem unless the parents go to join the child in these nocturnal activities. If they

do, the baby will learn to call and expect the parents to come.

Night waking with crying often reappears, after an illness, perhaps with "teething", but often without an obvious explanation. It is not due to hunger even though the baby may go back to sleep more easily after a suck, especially if mother goes to him/her while she still carries his/her milk supply. Many parents can pat the child to sleep and be back asleep themselves within minutes. It is only a problem if the parents see it as such, and then the problem may have to be seen as a disciplinary one.

Disturbed sleep patterns may be induced by holiday trips or by the anxiety of a maternal separation or a hospitilisation. Dummy dependency as seen at four to six months of age can continue into this period.

Nightmares do occur in this age group. A nightmare is recognised by the fact that the infant continues to scream even though picked up. Actually, he/she is not awake even though the eyes may be open. Such situations need parental soothing after the infant has fully woken.

Prevention of problems is very important at this stage. Babies who talk or sing to themselves are not asking for company. If babies learn to suck their fingers or thumbs in order to go to sleep or to stay asleep, they do not call out when their dummies fall out. Bottles or breast feeds are best avoided at night once the baby has slept through the night for over a week or so.

The management of problems at this age depends totally on whether or not the family is being disturbed and sees it as a problem. Slow resolution of the problem does occur if nothing is done, but it may take months or years. Many paediatricians following the teachings of Professor R Illingsworth and others recommend that the only way to quickly settle a baby who, having slept through the night, wakes frequently and unnecessarily, is to let him/her cry it out so that he/she learns that night time is for sleeping. As Brazelton puts it: "It is important to condition the infant as early as possible to use his own resources for returning to sleep". However, failed treatment adds to the severity of the sleep disturbance and may lengthen the time it takes to resolve. Success depends on the strength and resolve of the parents. They may need a lot of support from professional sources in order to handle the situation.

For the ten percent of infants who have never slept through the night, it is probably best not to force the issue before the first birthday. Again, the need for treatment depends totally on whether or not the infant's behaviour is really disrupting family psychodynamics.

The use of a night light, quiet music near baby's head, a cuddly toy, or similar techniques may help. Sedatives are not of any great value except as a brief support mechanism in a crisis situation.

SLEEP PROBLEMS BETWEEN THE FIRST AND THIRD BIRTHDAYS

It is probably a natural childhood desire (or, perhaps, a need) to sleep with someone. Whether or not parents allow the toddlers to sleep with them is their own decision. If it is allowed consistently, the child will probably keep it up until he is about six years of age. Children of two or more frequently refuse to go to bed without a repetitive performance of such things as having a drink, wanting to go to the toilet, kissing everyone goodnight, expecting a story read, and so on. Some parents view these activities as normal, others as disciplinary issues.

OVERANXIETY AND SLEEP PROBLEMS

Overanxiety seems to be almost universal in mothers of first babies and very common in the community at large. It may be part of the individual's make-up, having been transferred from the previous generation. It may be coincidental with the arrival of a baby about whom mother knows little and for whom she has had no preparation or previous experience. The anxiety can also be societal in origin in that there is a societal pressure to succeed and a societal attitude that parenting is easy.

The overanxiety of parents is picked up by babies within days of birth and can determine their behaviour thereafter. It may lead to crying babies and sleepless babies. When "up-tight" one cannot relax enough to go to sleep irrespective of one's age.

The overanxiety of parents can also distort childrearing by inducing fear in the child and perpetual clinging. The child is not allowed to experience the normal stages of development without fear and may not be allowed the exploring that is essential for normal learning.

One essential factor in the treatment of overanxiety is education in that expertise and understanding must diminish the anxieties of child rearing.

SUMMARY AND CONCLUSIONS

Sleep problems are best prevented rather than treated. This requires an understanding of the processes involved and that the parents understand the choices of treatment and be able to define which are appropriate to the family personality.

Poor sleep leads to overtiredness which, if persistent, may lead to major behavioural problems by one year of age. Overanxiety pervades a great deal of child rearing. It causes or aggravates sleep problems and compounds the problems of overtiredness.

FURTHER READING

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FRUSTRATING CHILDREN:

FROM BIRTH TO PRE-SCHOOL

Dr Michael J Harris

Excessive levels of parental frustration are very common in our society. These are reflections of inadequate preparation for parenthood and the lack of effective support systems when parents find themselves under increasing pressure in the area of child-rearing practice. It is perhaps understandable that these frustrations sometimes (though rarely) lead to infanticide. They surely explain a great deal about the reasons for child abuse.

This paper will deal firstly with babies in the first four months, secondly with toddlers and thirdly with the pre-school child. Although a continual current of family dysfunction can run through the entire childhood period, there are age-specific maladjustments.

THE FRUSTRATIONS OF LOOKING AFTER BABIES

Four major problem areas will be considered in this section, namely,

1) the excessive crier
2) the poor sleeper
3) the difficult feeder
4) the "out-of-joint" baby

The Excessive Crier

Few things unnerve a new mother more quickly than a continued crying spell. Most mothers are distraught after several hours of this. Some become hysterical after a day of it. Despite these reactions, too often it takes several weeks before some will look for help.

The physical causes of the crying, screaming or the "colicky" behaviour include a number of well-defined medical sources of pain such as from the gut, the urinary tract, or the nervous system. Cow's milk intolerance is also a recognised cause of abdominal pain and crying in babies. These are discussed elsewhere (Harris, 1982).

The non-physical causes of excessive crying are those factors which produce the "out-of-joint" baby and are discussed below.

The Poor Sleeper

This topic has been covered in the first part of this Selected Paper, *Overtiredness, Overactivity and Sleep.*

In brief, some babies have great difficulty in learning to relax in order to go to sleep. This usually occurs if they are the "out-of-joint" baby.

The Difficult Feeder

Hunger is a potent cause of screaming and many breast-fed babies who frustrate their mothers with their failure to sleep and their persistent crying are actually hungry. The effect of giving extra food usually demonstrates the correctness of this diagnosis.

There are breast-feeding mothers who don't really like breast-feeding. They do it because of social or other pressures and they resent the baby's keen desire to attack, lick, suck and enjoy their breasts. It is not surprising that these babies sense their mother's resistance, begin to fight feeding, cannot relax, and become difficult.

Some babies get their feeding too quickly and some too slowly from either breast or bottle. Either can produce distress and crying in the baby with corresponding frustration to the adult who feeds.

Feeding time for babies should be one of close emotional contact and warmth. Consequently, "out-of-joint" babies are likely to be temperamental, if not frankly difficult, feeders.

The "Out-of-Joint" Baby

This unsatisfactory term is used to describe the baby who is "not right" because the fit of baby into the slot of family is not snug - it is "out-of-joint".

The "out-of-joint" family can have problems that derive from mother, father, siblings, their inter-relationship or from the baby. Any misalignment of the cogs of the wheel that is the family, leads to a poor performance by the wheel as a whole and each cog then contributes to the malfunction, and is influenced by that malfunction. All too often it is presumed that mother is the cause of the problem. This presumption may be made believing that mothers are more amenable to treatment and more responsive to guidance. These presumptions are not true, are unfair and may explain treatment failure.

a) A frequent maternal problem is that of unreal expectations of pregnancy and/or of labour and/or of the baby. This latter may be so unrealistic that anything other than a mute doll may be a threat. Many coping mothers comment on the surprise they have when they realise in the first weeks after delivery just how much emotional demand a baby imposes on them. Many mothers revel in this new emotional climate while others are tremendously threatened and even frightened by it.

   The unreal expectations of some mothers in their own capacities is a frequent cause of severe early frustration. This applies particularly to the women who competently mix domesticity with professional and personal pursuits. This disruption caused by a new child, the associated tiredness and anxiety, shatters her composure and self-reliance. She has often been told by society that mothering is easy, comes naturally, and is not very important anyway.

b) Some mothers may be physically unwell after delivery or have other chronic illness. If these are undiagnosed then this can lead to unfair blaming of the mother for the malfunction of her family.

c) Maternal/infant bonding is the process by which the pregnancy becomes desirable, the labour bearable and the off-spring important. Some babies remain unwanted after birth. Some babies do not bond with their mothers after birth for reasons discussed in the next paragraph. Some have poor bonding experiences because of neonatal illness, injury or hospitalisation. The care of mother/infant relationships while babies are in intensive-care nurseries is currently receiving a lot of attention from paediatricians and related workers.

d) For some parents, problem babies may be physically abnormal, may have unexpected physical features, or may be the wrong sex. These stigmata may reflect badly on this child's acceptance by the family for periods ranging from days to decades.

e) Some fathers have little idea of their role and even less of that of the mother. They are challenged by mother's involvement with the child, unsupportive of her needs and unaware of the behaviour patterns of babies. All these add to the dysfunction of the family unit. The role of fathers has been discussed in some detail by Patterson (1982).

f) Parental dysfunction contributes to the frustration of child rearing. If there is little or no joy in the relationship, or if there has not been time for the couple to establish a meaningful relationship, then the emotional burden of a third family member will strain and may shatter the adult relationship. Babies virtually never save the "rocky" marriage, and pre-delivery counselling in these cases is advisable for everyone's sake.

g) Rigidity of approach by one or both parents can lead to frustrations. On one side, the adult may expect to be able to continue a life-time of self-governed attitude, thought and activity. On the other, the baby has not been subjectd to this long-term approach and may well have impulses of his/her own. The inevitable effect of age, experience and interpersonal influences on each adult must be recognised.

h) Overanxiety about babies is often part of the parental emotional make-up. In excess, it is a potent cause of frustration as the fears of day-to-day management build up. It produces stress in the baby who becomes a persistent crier and a vicious cycle of malfunction evolves. Parental education about normal baby behaviour is often only part of the answer to this problem.

i) There are normal babies who don't like to be cuddled excessively. There are strong-willed babies who very early express likes and dislikes. There are ritualistic babies who dislike even minor changes in their daily routines.

THE FRUSTRATIONS OF LOOKING AFTER TODDLERS

The "unloved" toddler (and child) attention-seeks, may refuse to be disciplined and frustrate his/her carers excessively. Of course, this frustration will not occur if the "carers" don't care, don't pay attention, or don't respond back - if they are around at all.

The "loved" toddler frustrates in 4 main areas:

1. poor sleep patterns and overanxiety
2. food refusal
3. misbehaviour
4. training problems

Abnormal sleep and overanxiety have been discussed elsewhere (Harris, 1982; see also part 1 of this paper).

Food refusal is typical of the 1 - 2 year old child who normally has a lessened appetite in comparison to the 1 - 9 month old baby. This physiological drop in appetite is often periodic so that the toddler may eat poorly for days or weeks on end, and then eat ravenously for several days. To the overanxious mother, to the "food equals health" or "food equals love" mother, this is a matter requiring immediate treatment which does not exist, thus extreme frustration is a result. However, the child has the ultimate say as to what passes his/her lips and what stays in the stomach. The child will inevitably win any confrontation in this area.

Frequently, there is also a dramatic drop in the variety of food that this age group eats. They may get the vast bulk of the food intake as milk or as one or two other food types and although, in some cases, there may be reason to give extra vitamins, this is rarely indicated on medical grounds.

Misbehaviour frustrations represent an area of parent/child conflict in which the parental background and expectation have a strong influence. The distinction between what is normal toddler inquisitiveness and curiosity on one side, and what is unacceptable on the other, may be clear to the parents, but often it is not. In our society today, the distinctions are blurred by social, economic and personal pressures especially those which fluctuate daily and which determine the parental behaviour day by day. The personalities of each parent and the child are highly relevant to these conflicts and frustrations.

The need for guidelines of behaviour is fundamental to children. So too, is their desire to learn adult skills. Discipline is the means for ensuring the success of this learning process. Many parents believe that learning must be accomplished by bullying, badgering and beating. However, it can also be achieved by coaxing, teaching and assisting. The former technique leads to frustration on the part of parents and child with continual screaming matches, physical exchanges and resistance or indifference from the child. A vicious cycle of defiance by the child inducing more anger and bullying by the parents is not uncommon from even 15 - 18 months of age. Appropriate parental behaviour often requires know-how which is not always at hand. Exhibiting such behaviour can be demanding and tiring (especially if it doesn't come naturally), but the effects on the child make it worth the effort.

The management of these problems involves making all parties aware of their respective rights and finding means by which the child learns to respect

parental demands (Harris, 1982).

Toilet training is viewed by many parents as the most important landmark in the development of early childhood. Social acceptability of both parents and child, for many families, seems to be related to being "trained". It is a matter of vital importance for those who see "cleanliness" as "godliness" or, at the other extreme for those who can't stand washing soiled nappies. Although some parents expect their infants to be trained before the first birthday, most can wait another year. Nevertheless, failure of toilet training is a potent cause of physical abuse of children.

This is another area in which the child has total control over the situation. He/she will only evacuate when he/she wishes to. No degree of coercion will influence the child unless he/she wishes. The closer to the age of two, the easier it is to "train" a child. Nevertheless, the parental frustrations over training are often monumental.

FRUSTRATIONS INDUCED BY THE PRE-SCHOOL CHILD

These relate to a number of main areas:

1) tantrums and other misbehaviour problems
2) stubbornness
3) "selective deafness"
4) refusal to be bustled
5) toilet training problems
6) clinging

Behaviour Problems

These are usually a continuation of toddler misbehaviour as a result of the parent not being successful in coaxing, teaching or otherwise assisting the toddler to learn a few basic, easily understood rules. When there is complete breakdown of established discipline the child is uncontrollable and whatever the parent does is totally ignored. Any parental intervention is likely to be followed by a tantrum with kicking and screaming. These kinds of tantrum usually mean that the child has learnt another means by which he/she gets whatever is wanted, often because the parents have not clearly and consistently indicated what is acceptable behaviour.

The tantrums of frustration in which the child is angry with him/herself at being unable to accomplish a particular adult skill or to properly use an adult instrument, should not be seen as misbehaviour. These tantrums usually occur between two and 3 years of age; beyond four, most children are fairly competent with manipulation and get frustrated less quickly. The tantrums of frustration are best avoided by keeping the child involved with manipulations he/she can manage, by calming him/her during frustrating periods, and by teaching him/her correct techniques where possible.

Management of behaviour breakdown at this age usually involves considerable assessment and counselling by appropriately trained personnel (Harris, 1982).

Stubbornness

In practice, this temperamental characteristic of children, seems to be familial and in-built. Many parents need to be reminded that it takes two to be stubborn - one to insist and one to refuse. The fact that a given child may have "inherited" this stubbornness from one or other side of the family does not necessarily make life easier - but it at least makes it clear to the parents that they themselves should come to terms with the problems first. They should be absolutely "fair" in their dealing with the child - most children will begin to respond to "fairness" and to an understanding of the reasons for requests of discipline in the pre-school period.

Very often, if a child and a parent are confronting each other eye-ball to eye-ball, the child wins. It is wisest to avoid such confrontations in order to avoid reinforcing this kind of behaviour. Diversion or turning the confrontation into a game is often a useful technique.

"Selective Deafness"

This refers to the situation in which a child cannot hear mother calling but can hear the lolly-jar rattle faintly. Short of military-type child-rearing, some of this is inevitable. Often, it is a reflection of the child's total involvement in whatever he/she is doing at that point of time and which must be completed for the child's self-satisfaction. This occurs especially with the highly motivated and intelligent child.

Sometimes it reflects the fact that the parents continually rant and rave anyway, and the child is conditioned to ignore it all. This aspect of "selective deafness" is often associated with tantrums and/or stubbornness and must be treated in the same way. Sometimes, it can occur because of recurrent ear infections and real (though hopefully temporary) deafness. Such possibilities must be checked by appropriately-skilled professionals.

Refusal to be Bustled

Three-year-olds have little concept of time - they are just beginning to accept "today", "this morning", and "this afternoon". By five, they understand up to seven days ago or hence, and are getting an idea of the hours of the day. They do not understand mother's three o'clock appointment with the dentist, or an afternoon shopping excursion, or trip to the beach. They do not bustle themselves and they do not like being bustled by others. This is inevitably a problem, but especially so when the parents are "high-powered", move quickly, achieve and don't relax.

Children who are concentrating on a particular job, task, game, project or whatever, should be left to complete it whenever possible. They should be given a lot of time and several warnings of projected activities which will take them away from whatever enthralls them. If they have had time to finish some activities, the reasonable child will accept some bustling. It is merely another example of the give-and-take that characterises satisfying and satisfactory adult/child relationships.

Toilet Training Problems

The child who has never been trained by the age of three may be so aggressive in his/her relationship to his parents/carers that he/she has translated this into total toilet refusal. Often the child is overtly unwanted and/or unloved.

At the opposite extreme, the parents may have ignored all signs of the child's being ready to train. This can occur because of indifference, nonchalance or a deliberate policy of non-intervention.

Relapse of toilet training is not uncommon beyond the age of three and is very frustrating for parents, who thought they had achieved so much. Most often, it follows an emotional crisis, especially separation from mother (usually over the birth of a new baby) and will be discussed below. It may involve either bladder or bowel control or both.

The child who continually soils his/her pants usually has a problem of overflow with chronic constipation. This child has no control over bowel function and needs medical assessment and treatment. When medical intervention fails, psychiatric help for child and/or family may be needed.

Clinging

Children of any age may want to climb up onto a parent's knee and "play" at being a baby. The secure child from about eighteen months will play alone for lengthy periods in the day, but will not necessarily be happy away from mother's sight. The two-year-old who is familiar with the play-group situation may separate from mother/carer for up to an hour or so. With increasing age, the time-gap away from mother/carer also increases, but the child still requires the knowledge that the mother/carer is available in "crisis" (as seen by the child).

A clinging three-year-old means that there has been a disruption in the continuum of development of independence. It strongly suggests a disruption of the child/parent/carer relationship. It can occur in the unloved child, the unwanted child, the child who has had a multitude of homes and carers. It does not have to happen in all such children as some seem to have a defence mechanism against the destructive effects of this type of background.

In the ordinary course of events, the commonest cause of such emotional disruption is maternal separation and this usually occurs with the hospitalisation involved with the birth of a sibling. When mother comes home the older child clings, attention-seeks, and may sleep poorly as he/she looks for the reassurance of his/her mother's involvement with him/her. Any significant pushing away or ignoring of the older child's legitimate demands only increases the insecurity induced by the separation. This will also allow the older child to see that the baby is the reason for being pushed away, and this is the origin of sibling jealousy.

Another example of clinging based on a feeling of poor security includes the mother who doesn't say "goodbye" to her child (of even 12 months of age) when she goes out or leaves the child with another carer for a couple of hours. This child is never able to be sure that mother is around and hence, clings frantically. This is unacceptable parental behaviour both from this point of view and from the viewpoint of learning/teaching basic

honesty.

Other causes of clinging are the overanxious parents who have transmitted their overanxiety to the child. This child is continually frightened, worried, upset and clings. In fact, there will be symptoms from continued overanxiety at every age.

SUMMARY

Parents very easily become frustrated when they don't know much about babies. As the parents become more confident, frustrations are more related to particular behaviours and/or to the outside pressures on those parents.

The levels of frustrations are often such that parents want to give the baby away or even injure it. Where there are support systems available, parent and child come to terms with each other. If not, tragedies can occur.

REFERENCES

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